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Correspondence

Letters to the Editor should not exceed 500 words.

Computers on the March

SIR,—Your leading article "Computers on the March" (18 October, p. 124) highlights only a few of the problems of introducing computers into medicine. Dr. J. H. Mitchell (18 October, p. 157) underlines two basic difficulties, which I believe will prevent the computer from intruding further into the clinical field.

Firstly, the history obtained from most patients in a busy outpatient department or ward is likely to be put together in a somewhat disjointed fashion ; this depends on the mutual concentration, interest, and experience of the doctor on the one hand and the ability to communicate, the actual illness, and the state of mental anxiety of the patient on the other. The resulting data are bound to be "vague and unreliable," to quote Dr. Mitchell, and can never be suitable for computer input. Conversion of these human facts into "standard" questions and "standard" answers requires a vast increase in secretarial and programming personnel, a great deal of added "time per patient," and is plainly unworkable in the National Health Service.

Secondly, the record of examination of a patient can only contain certain parameters of objective assessment—for example, temperature, pulse, blood pressure—and these can be notoriously unreliable at a first interview. Other findings at a preliminary, and often cursory, examination are purely subjective, and depend considerably on the skill, experience, and individual variation among doctors. Such data are likewise unsuitable for programming a computer.

In certain areas of hospital work computers are invaluable, but in the strictly clinical field I feel that the only time that the medical profession will consent to using a common terminology of computer language will be when "standard" doctors are turned out at the end of "standard" courses from "standard" medical schools, and when their patients stop being human.—I am, etc.,

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SIR,—After a rather tardy start the medical profession in Great Britain is seriously contemplating the use of computers in this the most conservative of professions. As Dr. M. Marinker points out[1] there are several studies going on in general practice attempting to computerize records. A number of Scottish and English hospitals have tried to computerize small areas of their records.[2]

Dr. D. E. Clark[3] tells us that 75% of the activity of a hospital is concerned with the processing of information. Jydstrup and Gross[4] inform readers that the present cost of a hospital's information system or processing techniques is much higher than we appreciate, and may be as much as 25% of the total hospital operating budget.

It is indeed disappointing to see the article by Dr. J. H. Mitchell (18 October, p. 157), a distinguished expert on the processing of medical records, in which he condemns exciting research and investigation into this field as "fantastically elaborate and expensive." When the process of recording and retrieval of information is of such importance, then expensive schemes are valid. The storage of many patient/years of information is a simple and economical computer process, and destruction of records may well meet with condemnation from our successors in their studies or topics of interest and research into our diseases of the 60's and 70's. Our danger is not the diversion of attention from more valuable uses to which computers might be put, but reluctance to spend time and effort on the resources at hand and to learn how to use them to their full efficiency. —I am, etc.,

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1 Marinker, M., *Practitioner*, 1969, **203**, 285.
2 Kennedy, F., Roy, A. D., Cleary, J. J., and Kay, A. W., *Lancet*, 1968, **2**, 1230.
3 Clark, D. E., *Practitioner*, 1969, **203**, 313.
4 Jydstrup, R. A., and Gross, M. J., *Health Services Research*, 1966, **1**, 235.

Mobile Coronary Care Teams

SIR,—We believe that it would be singularly unfortunate if the concept of prehospital coronary care were to be judged by the results reported by Dr. H. A. Dewar and his colleagues (25 October, p. 226). The poor results obtained by the Newcastle unit, in contrast to the results obtained by the Belfast Mobile Coronary Care Unit,[1-4] are due to fundamental differences in the operation of the units.

In Belfast the emphasis is on early initiation of coronary care ; thus the median time between onset of symptoms and the initiation of coronary care by the mobile unit is two hours, and 26% of the patients managed by the Belfast unit are under intensive care within one hour. In contrast, the mean time quoted by Dr. Dewar and his colleagues is four and a half hours. Since the majority of deaths from myocardial infarction occur within two hours of the onset of symptoms, the Newcastle unit will have little effect on the mortality. It appears that the general practitioners of Newcastle upon Tyne have been ill informed as to the type of patient who is most likely to benefit from immediate